Annual Report of the Health Insurance Benefits Advisory Council

July 1, 1971—June 30, 1972

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U.S. Department of Health, Education, and Welfare
Social Security Administration
Bureau of Health Insurance
March 1973

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January 16, 1973

Honorable Elliot L. Richardson
Secretary of Health, Education, and Welfare
330 Independence Avenue, SW.
Washington, D.C. 20201

Dear Mr. Secretary:

Pursuant to Section 1867(b) of the Social Security Act, the Health Insurance Benefits Advisory Council herewith submits for transmission to the Congress its annual report on the Council's activities and operations, including the recommendations it has made for changes in program administration or for legislative provisions.

Sincerely yours,

James R. Cowan, M.D.
Chairman
Health Insurance Benefits
Advisory Council

Enclosure

Membership of the Council

Carl E. Anderson, M.D., Clinical Professor of Orthopedic Surgery at the University of California Medical School and member of the staff of the Santa Rosa Memorial Hospital, Santa Rosa, California

Melnea A. Cass (Mrs.), Chairman, Massachusetts Advisory Committee for Elderly Affairs

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I. Introduction

A. Responsibilities of the Health Insurance Benefits Advisory Council

Under section 1867 of the Social Security Act, the responsibilities of the Health Insurance Benefits Advisory Council (hereafter called the Council) have been (1) to advise the Secretary of Health, Education, and Welfare on matters of general policy in the administration of the Medicare program and in the formulation of regulations governing the program; (2) to study the utilization of services payable under Medicare, with a view to recommending desirable changes either in the way those services are utilized, in Medicare administration, or in title XVIII of the Social Security Act; and (3) to report annually to the Secretary on the performance of its functions.[1] The report which follows is intended to fulfill the last requirement for the period July 1, 1971–June 30, 1972, but also reflects certain subsequent developments at the time of its transmittal. The Social Security Amendments enacted October 30, 1972, provide for the Council to advise the Secretary on matters of general policy with respect to both the Medicare and Medicaid programs. Therefore, this will be the last report of the Council oriented solely to Medicare.

B. Major Concerns and Activities

In fulfilling its responsibilities to advise the Secretary on matters of general policy in the administration of the Medicare program and in the formulation of regulations, and to study the utilization of services payable under Medicare, the Council concerned itself mainly with issues that were of immediate and direct concern to Medicare beneficiaries and the providers of Medicare services. These issues came within the broad categories of (a) the quality of health care, (b) utilization of services, (c) reimbursement for covered services, and (d) administration of the program. The Council's recommendations on these issues are discussed in section II. Activities which resulted in no formal Council recommendation during the reporting period are described in sections III and IV.

[1] In accordance with Executive Order 11671, issued in June 1972, meetings of the Council have been open to the public since July 1972. Advance notice of the time and place of all meetings is given in the *Federal Register*.

II. Summary and Discussion of Recommendations

A. The Quality of Care

1. *Patient Care in Health Maintenance Organizations (HMO's)*

> *The Council recommended that specific requirements for monitoring and coordinating patient care appear in the form of regulations rather than as part of the statutory definition of a health maintenance organization and that these regulations provide for alternative mechanisms for monitoring and coordinating patient care and allow leeway for innovation in developing equivalent mechanisms.*

The Council reviewed the language of H.R. 1[2] defining HMO's for Medicare purposes, and, because of the Council's interest in assuring a high quality of care for Medicare beneficiaries, paid special attention to the question of whether or not to recommend a modification of the legislative definition of an HMO to require that each beneficiary be under the care of a primary physician who would assume responsibility for the coordination and continuity of the beneficiary's care. Agreeing that specific requirements for monitoring and coordinating patient care should appear in the form of regulations rather than as part of the statutory definition of an HMO, the Council decided against recommending a change in H.R. 1's definition. The Council further agreed that regulations governing HMO's should permit alternative ways to monitor and coordinate patient care and should allow leeway for the development of innovative methods.

In reaching these conclusions the Council considered, among other factors, that there might not be enough physicians available to handle the additional workload, that ancillary personnel such as nurses might be able to handle effectively the job of coordinating a patient's care, and that prepaid group practice plans, on which HMO's are largely patterned, use a variety of methods to achieve coordination and continuity of care. Finally, the Council believes that, if an HMO is not a responsible one, merely citing a personal physician to be responsible will not assure achievement of the objective. If the organization is a responsible one, it will assure that proper health care is rendered to its members in compliance with the language of H.R. 1 that an HMO assure "that the health serv-

[2] H.R. 1 was enacted on October 30, 1972 as Public Law 92–603. Unless otherwise stated, references to H.R. 1 in this report are to the version passed by the House of Representatives; the Senate did not act on H.R. 1 until well after June 30, 1972.

ices required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations."

2. *Standards for Physicians*

The Council withdrew its earlier recommendation that the Secretary seek the development of standards for physician participation in the Medicare program.

As an earlier Council report pointed out, the Secretary of HEW does not have the authority to set standards of participation in the Medicare program for physicians, as he does for hospitals, extended care facilities, home health agencies, independent laboratories, etc.[3] Having reviewed the efforts (undertaken since July 1969, when the Council recommended that the Secretary "seek the development of feasible and desirable standards of eligibility for the rendering of various types of medical services by physicians under the Medicare program . . .") to raise the quality of, and specify standards for physicians' services, the Council decided that it did not now recommend a study of the feasibility of establishing standards for physician participation in the Medicare program and withdrew its recommendation that such standards be developed.

Among the efforts reviewed by the Council were those of the American Medical Association, State medical societies, and medical specialty associations. These efforts indicate a trend in the private sector toward the establishment of higher and more uniform standards for physicians, principally in the area of continuing education.

In withdrawing its earlier recommendation that standards for physicians be developed, the Council also took into account the sensitivity of physicians to the issue of government regulation, the inability of recognized experts to reach accord on uniform standards for physicians, and difficulties in the creation of effective administrative mechanisms to enforce standards for physicians. The Council intends, however, to keep informed of the results of recent promising programs in various parts of the country aimed at improving the quality of physicians' services and the long-range results of the activities

[3] Annual Report on Medicare, July 1, 1966—December 31, 1967, p. 9.

of the Professional Standards Review Organizations provided for in Public Law 92–603.

B. Utilization of Services

1. *Covered Services in HMO's*

The Council recommended that an HMO be required generally to provide, either directly or through arrangements with others, all of the services and benefits covered under Parts A and B of the Medicare program.

The provisions of H.R. 1 require an HMO to provide all the services covered under title XVIII of the Social Security Act. Because some HMO's may be located in relatively isolated areas, the Council considered whether or not to recommend a modification of this requirement which would give the Secretary the authority to excuse HMO's from the provision of some services which could not feasibly be required in an isolated or rural area.

While the Council recognized the difficulty in providing all services in all areas, under present law beneficiaries are eligible to receive Medicare covered services even if they must travel some distance to obtain them. The Council felt that the services should be available through rural HMO's to the same extent that they are available under general medical practice in an area and that it would be difficult to justify a policy under which beneficiaries in HMO's are eligible for fewer benefits than other beneficiaries. Therefore, the Council supported the requirement in H.R. 1 that an HMO generally provide, either directly or through arrangements with others, all of the services and benefits covered under title XVIII.

2. *Physician Certification of Medical Necessity of Inpatient Hospital Services*

The Council recommended that additional data be obtained before consideration is given to changing the existing regulations which require a physician certification and recertification of the medical necessity of inpatient hospital services on the 12th and 18th day of a beneficiary's hospitalization.

One of the provisions of title XVIII of the Social Security Act intended to prevent the improper utilization of covered services is that which requires physicians to certify in writing that their patients have a medical need for inpatient hospital

services before Medicare benefits may be paid for a hospital stay. As authorized by Section 1814 of the Social Security Act, the Department of HEW originally set the timing for the required certification (and recertification) at the 14th (and 21st) day of hospitalization. Because, during the early years of the Medicare program, hospital discharges peaked significantly on the 14th (and 21st) day of hospitalization, with the Council's endorsement the regulations were changed in 1970 to require certification on the 12th and 18th days in the hope that a reasonable shortening of the certification periods would reduce hospital stays. (The change increased the number of certifications that are required by about 600,000 in 1970, i.e., an average of about two or three additional certifications per physician.) The Council decided to review the timing of required certifications to ascertain whether or not a change was warranted at this time.

Comparison of available data for 1967 and 1970 showed a continuation in 1970 of the pattern of peaking on the 7th and 14th days as well as the 21st and 28th. However, the Council felt that the data were inconclusive and, after considering alternatives to the present timing of certifications, came to the conclusion that further study of more complete data would be necessary before it could consider a change in the timing of certifications. Such a study was planned for fiscal 1973.

C. Reimbursement for Covered Services

1. *Implementation of the Wage-Price Freeze and of Phase II Controls*

The Council supported efforts by the Bureau of Health Insurance, in cooperation with the responsible executive branch offices, to develop Medicare policies aimed at exerting anti-inflationary influences on rising health costs and take an important role in contributing to Phase II of the Economic Stabilization Program.

Early in the fiscal year the Council considered the possible effects on Medicare of the temporary wage-price-rent freeze.

Although HIBAC recognized that rulings to implement the freeze would be issued by the Cost of Living Council rather than the Department of HEW, it felt that its discussion of issues and problems related to the freeze would be helpful to the Department in its submittal of requests for rulings to the Cost of Living Council.

As a body, HIBAC took no formal action on specific freeze issues, but comments by individual members during the Council's discussions helped in the submittal of such questions as:

a. Under the hospital insurance (Part A) program, where reimbursement to providers of services is retroactive and is based on their allowable costs, should increases be allowed that did not arise from increases in prices, salaries, or wages?

b. Under the supplementary medical insurance (Part B) program, should increases in charges by individual physicians and other suppliers of services be allowed? Should recognition be given to increases in charges during the freeze for purposes of establishing reasonable charge screens based on 1971 charges?

The Council also advised the Secretary on policies developed to control the escalation of health care costs in the period following the temporary freeze. Acknowledging that retroactive cost reimbursement under Part A and the use of customary and prevailing fee profiles under Part B introduced an element of delay in recognizing increases in payment levels, the Council, nevertheless, suggested the need for definitive guidelines to contain costs. Accordingly, early in the fiscal year the Council supported efforts by the Bureau of Health Insurance, in cooperation with the responsible executive branch offices, to develop Medicare policies aimed at exerting anti-inflationary influences on rising health costs and to assume an important role in contributing to the economic stabilization program that was expected to follow expiration of the temporary wage-price-rent freeze.

Subsequently the Council reviewed and commented on proposals to implement Phase II of the President's Economic Stabilization Program under Medicare. Helpful to the Council in this endeavor were the first-hand reports it received from its Chairman, who is a member of the Health Services Industry Committee, which was appointed to assist the Cost of Living Council, the Price Commission, and the Pay Board in formulating guidelines to stabilize the rapidly rising cost of health care services. In addition to receiving reports from the Chairman on the Phase II guidelines, the Council was apprised by Medicare staff of the manner in which these guidelines were being applied in the reimbursement processes of the Medicare program.

2. *Incentive Reimbursement Experimentation Program*

With the proviso that the statistical model for it be developed to the satisfaction of the Social Security Administration, the Council recommended approval of the incentive reimbursement experiment proposed by the Birmingham (Alabama) Regional Hospital Council.

The law authorizing experiments with various methods of reimbursement to institutions and payment to physicians under Medicare and Medicaid provides that no experiment be developed until the Secretary consults with and takes into consideration recommendations of recognized specialists in the health care field who are qualified and competent to evaluate the feasibility of the experiment. In 1970, the Council assumed the responsibility for reviewing experimental proposals.

During fiscal year 1972, only one proposal—a target rate incentive reimbursement experiment developed by the Birmingham Regional Hospital Council—was submitted to the Council for review. The Council approved the reimbursement concept in the proposal and encouraged continued work on the statistical model for the proposal, which the Council felt had some promise but had not yet been sufficiently developed for conclusive evaluation.

Although some effort was made by the Department of HEW to publicize the incentive reimbursement experimentation program and to encourage the development and submittal of experimental proposals, the expected response from the health care field has not materialized. From the inception of the incentive reimbursement experimentation program through fiscal year 1972, in addition to the Birmingham proposal, four other experiments were approved. These experiments were proposed by the following organizations: (a) Connecticut Hospital Association, (b) Blue Cross of Southern California, (c) Health Insurance Plan of Greater New York, and (d) Maryland Blue Cross.

D. Administration

1. *Data and Claims Processing Systems*

The Council recommended that the Social Security Administration continue to develop improvements in data and claims processing systems and recog-

nized as one promising avenue for further exploration concepts aimed at improving transmission and collection of data relating to physicians' services and fees.

In the light of its continuing interest in research and development efforts which might be applicable to the Medicare program, the Council gave careful consideration to a proposal for an innovative system to increase coordination of the services provided by physicians while reducing their paperwork. This system would require that a data communication terminal be provided in the office of each participating physician. Through the use of computers the physician's information would be transmitted by wire directly to the appropriate third party and provide the physician's office with a printout of each medical insurance report. The medical data would be protected against unauthorized disclosure of information.

When authorized by the physician, the nonprofit corporation administering the system could present the physician's schedule of procedures and charges to the appropriate peer review organization for approval, and upon approval, arrange for prompt payment prior to claims review by the third-party health financing agency. The corporation would contract with third-party payers to provide them with details of their subscribers' physician encounters in an efficient, timely and accurate manner, including proper coding of procedures and diagnoses and prior certification of the peer review committee approval of procedures and charges when available.

The Council believed that the concept underlying the project was good but stressed the need for evaluating the proposal carefully in relation to comparable projects operating in different parts of the country and to their probable implementation costs, which appear to be quite extensive. Opportunities for success of a project of this nature require effective medical sponsorship and the Council suggested that this also be considered in evaluating the merits of the proposal.

In connection with its review of the proposal, the Council heard a presentation by its developer and asked a member of the Council to attend and report on a meeting designed to enlist support for the proposal. Though the Council did not recommend adoption of the proposal by the Social Security Administration, it recognized the need for continuing such innovative efforts.

2. *Minority-group Employment by Medicare Intermediaries*

The Council recommended that the Social Security Administration continue its aggressive, positive efforts to maximize minority-group employment at all occupational levels by Medicare carriers and intermediaries, including efforts to assure such employment in new business locations.

As a group composed not only of professionals in the health care field but the general public as well, the Council took a special interest in the efforts made by Medicare intermediaries, which help administer the program under contracts with the Federal Government, to have an affirmative equal employment opportunity program.

A shift of offices from urban centers to other locations has been occurring to some extent in the insurance industry, varying from company to company, and within each company. In the main, such shifts have been few, and have exerted relatively little impact on the overall minority employment records of the contractors. However, underlying factors continue that may have the effect of increasing the movement away from large urban centers to suburban areas and to smaller distant cities with small minority populations. These factors include location of selected sales markets, transportation, land and building costs, and the nature of the labor supply.

While most of the contractor offices conducting Medicare operations are located in cities with substantial minority populations, there are a number of Medicare units located in areas with low minority representataion. In some cases, the Medicare units are located at or near the home office—which may be located in or serving an area with relatively little minority population. In other cases, the Medicare unit is a field office located away from the home office, in a distant city with a very small minority population. In the latter cases, local transportation is not the obstacle to employment but rather the unavailability of minorities in the local labor market.

If the goal of equal employment opportunity is to be effectively implemented, it will be necessary for employers to take affirmative actions with regard to making jobs accessible to minorities at offices in suburban locations near minority-populated cities, and also at offices established in distant communities beyond the reach of daily transportation.

Medicare contractors appear to be successfully taking such actions.

A report to the Council showed that the minority representation in Medicare units is higher than in other units of the intermediaries' operations, and that there has been significant upgrading of minority members into positions which were not usually offered to them, e.g., sales and professional positions, including the computer programming field. The Council was encouraged by this report of progress and, in furtherance of its commitment to the principle of equal employment opportunity, urged the Social Security Administration to continue its efforts.

III. Summary of Other Concerns and Activities of the Council

A number of other important matters were brought before the Council for the views of its members to assist the Department in formulating its position. Although no formal action was requested of the Council on these matters, its advice and counsel resulted in significant modifications of several policies and new directions in efforts to resolve other problems.

A. Conditions of Participation

Extensive revisions in the conditions of participation for hospitals, extended care facilities, and independent laboratories were considered by the Council in 1972, and recommendations by Council members for changes in the organization and language of these regulatory standards are in the process of being incorporated. Of major concern to the Council was the need to simplify the existing regulations and to assure—especially under the proposed policy of publicizing the results of State agency surveys of providers of services—that only significant standards are included while the quality of care the standards are intended to protect remains at a high level.

B. Extended Care Facilities

As a result of observations made by Council members in various parts of the country, it was apparent that the extended care benefit and conditions in many of the nation's nursing homes were cause for concern. Among the problems which the Council discussed on several occasions during fiscal year 1972 were (1) disagreements over the level of care that is covered in an extended care facility, (2) the decision of a number of extended care facilities to drop out of the Medicare program, and (3) the tragic fires which occurred in several nursing homes. (These fires concerned the Council even though the ill-fated homes were not Medicare-participating.) Council members offered suggestions for coping with these problems and heard reports on what the Department was doing about them, including reports on the President's Action Plan on Nursing Homes.

To gain perspective on ECF problems from the point of view of those responsible for providing extended care, the Council heard presentations from the administrator and the utilization officer of an extended care facility in New Jersey. They reported their difficulties with the level of skilled nursing care required for Medicare coverage of extended care and their success in training staff physicians to become utilization-conscious.

C. Performance of Carriers and Intermediaries

Because the delivery of services and benefits to beneficiaries is dependent in large measure upon the administrative mechanisms for processing Medicare claims, the Council has been interested in the proper functioning of intermediaries and carriers. Those which have not adequately fulfilled their responsibilities have been given intensive review by the Social Security Administration, particularly during the periodic renegotiation of their contracts. Social Security Administration efforts to improve the quality and speed of claims processing have been explained to the Council. With respect to the recognized social responsibilities of intermediaries as contractors with the Federal Government, the Council has been informed of successful efforts to induce intermediaries to deposit Medicare funds in minority-owned banks. As part of its continuing effort to keep abreast of the administrative functioning of the Medicare program, the Council has heard detailed reports from social security regional office representatives and has been briefed on the claims processing activities of Medicare's Direct Reimbursement Branch, which serves as "intermediary" for those providers that have elected to deal directly with the Government.

D. Underutilization of Medicare Benefits

As part of the Council's concern with the overall problem of appropriate utilization of Medicare benefits, it has given consideration to possible underutilization of benefits by minority groups and others. As indicated in the Council's annual report for fiscal 1971, the utilization of extended care by nonwhites in 1967 occurred at a rate of only half that of the white population.[4] Studies undertaken to explain this discrepancy have not been definitive, and the Council has been informed that additional studies are in progress. Other data point to the possibility of underutilization among a spectrum of the aged population that is broader than the minority segment. For example, the percentage of beneficiaries who do not use any services for which they receive Medicare reimbursement is about 50 percent each year—21 percent use no services, an additional 29 percent don't use enough to meet the $50 deductible. In view of the likelihood that a high proportion of beneficiaries in the Medicare-covered age group are not in good health, the Council believes that further studies should be made to determine whether beneficiaries are prevented by various barriers from using services which they may, in fact, need.

[4] Annual Report of the Health Insurance Benefits Advisory Council, December 1971, p. 8.

E. Reimbursement of Providers of Services

In accordance with its interest in finding ways to speed up the cost determination process, the Council reviewed and discussed proposals to revise the methods available to providers of services for determining their Medicare reimbursable costs. Believing that the providers themselves should be given an opportunity to present their views before the Council, it invited a representative from the American Hospital Association to explain the AHA proposals embodied in that organization's "Statement on Financial Requirements." In reviewing the various proposals, the Council weighed their equity, probable implementation costs to providers, contribution to simplifying cost finding and reporting requirements, and effects on patterns of utilization in special care units such as intensive care units.

A special aspect of provider reimbursement under Medicare which the Council discussed was the possible inequity to newly established providers in the regulations requiring disallowance of out-of-line costs. Under Medicare, health care institutions are reimbursed only for their reasonable costs and do not have an opportunity to offset less-than-cost reimbursement during their initial period of operation with later cost-plus reimbursement. During its discussions, the Council examined the relationship of possible remedies to the need for Medicare to support the decisions of area wide comprehensive health planning agencies and to the provisions of H.R. 1. Also discussed was the question of whether or not to apply the present guidelines to future periods only rather than to all unsettled periods.

F. Appeal Rights of Beneficiaries

If his claim for Medicare benefits is turned down or a decision is made to terminate benefits he is receiving, an applicant has the right under the Social Security Act to request a hearing on the decision—under Part A before a Federal hearing examiner, under Part B before a hearing officer of the carrier. Learning that backlogs had built up in requests for reconsideration of Medicare claim decisions and that a group of beneficiaries whose benefits had been terminated had filed a court action to have their benefits resumed until a decision on their Medicare claims is rendered by a hearing examiner, the Council explored possibilities for expediting appeal procedures. One suggestion was to use law students to conduct informal hearings in or near the applicant's city of residence. The Social Security Administration reported that efforts are underway to simplify the reconsideration and hearing process.

IV. Long-range Studies and Activities

During the year the Council embarked on, or continued, a number of long-range studies and activities which were intended to help the Council fulfill its statutory responsibilities. The status reports which follow should give readers a sense of some of the Council's goals for 1973.

A. Physicians Reimbursement Methods

The Council has established a committee to conduct an in-depth study of the methods of reimbursement for physicians' services under Medicare. The purpose of the study, which was set forth in H.R. 1, is to determine the effects of Medicare methods of reimbursement on (1) physicians' fees generally, (2) the extent of assignments of Medicare claims accepted by physicians, and (3) the share of physicians' fees which the beneficiary must assume. The results of the study will provide a basis for recommending to Congress alternatives to the present methods of reimbursement.

As part of this study, a sample physician survey was undertaken to determine if it was feasible to find out directly from physicians through personal interviews what factors they take into consideration in deciding whether to accept assignment, and what billing arrangements they make to cope with the deductible and coinsurance features of reimbursement. Interviews with a sample of physicians on the billing arrangements between them and Medicare patients revealed that the two main factors which physicians consider in deciding whether to accept assignment of a Medicare claim are the patient's ability to pay and the size of the bill. Since the results of this limited survey merely confirmed the Council's previous impressions, it was decided not to expand it to a nationwide survey. However, the survey did give the physicians interviewed in the sample an opportunity to make suggestions for improving Medicare's methods of reimbursement and showed that billing information could be obtained from most physicians.

Another part of the study is being conducted to obtain and analyze data from several sources for the purpose of testing the effects of Medicare's methods of reimbursement on (1) the prices physicians charge for their services, (2) utilization of physicians' services, and (3) use of the assignment method. Price information is being obtained from data on reasonable charges from Social Security Administration records, selected carriers, the California Medical Society index of physicians' fees and the Bureau of Labor Statistics. These data are being

arrayed to show variations in charges over time and among places, physicians, specialties, and procedures under Medicare. Utilization information is being obtained from the Current Medicare Survey—an ongoing survey which obtains information through personal interviews with a sample of Medicare beneficiaries on their actual experience under the Medicare program.

B. Nonutilization of Medicare Benefits

The Council has asked SSA to conduct a study into the reason why many individuals entitled to Medicare benefits do not actually utilize such benefits to determine if there are any significant barriers preventing them from using needed services. The study, which was just getting underway as the year ended, will use the Current Medicare Survey to show the demographic, geographic, and socio-economic factors associated with nonutilization of Medicare services.

C. Mental Health Benefits

A committee established late in the year by the Council to review the coverage of benefits for the mentally ill under title XVIII is initially focusing on the 190-day limitation for inpatient care in a psychiatric hospital and the $250 yearly limitation on Medicare coverage of outpatient psychiatric services.

D. Progressive Institutional Care

The Council has appointed a Committee on Progressive Institutional Care to coordinate and focus the Council's interest in a long-range study of this subject.

The purpose of the Council's study is to determine what can be done to provide Medicare patients with the best possible care at the least cost to the program by moving patients as quickly as their conditions warrant to less expensive modes of care; namely, from hospitals to extended care facilities, and from extended care facilities to their homes where home health agencies can minister to their needs. The Council expects also that the results of this study will point the way to basic solutions of the problems SSA experiences in administering Medicare's extended care and home health benefits.

E. Laboratory Services Performed by Non-Pathologist Physicians

In accord with a recommendation made by the Council that the Secretary seek to develop a study of the scope of laboratory services provided by physicians, other than pathologists, who

perform laboratory tests in their own offices, DHEW is developing, in conjunction with an advisory council made up of physicians, a questionnaire to be sent to the various physician specialists and general practitioners to solicit information on their practices with respect to laboratory services performed in their own offices. The tentative design for the questionnaire calls for covering such areas as personnel performing tests, scope of tests, equipment used, and why an independent laboratory is not used. The survey is scheduled to begin early in calendar year 1973.

V. Concluding Comment

During the past fiscal year, the Council made no recommendations for changes in title XVIII of the Social Security Act but had many discussions about changes proposed in legislation—primarily H.R. 1—which was pending in Congress during the period and which the Council anticipated would be enacted. Since the provisions in H.R. 1 relating to health maintenance organizations could have a major impact upon the delivery of medical care in the United States, the Council requested detailed reports on these provisions and on other legislative proposals relating to HMO's. Over the months, the Council had many discussions of these proposals to assure its keeping abreast of crucial deliberations of Congress. However, the Council found it difficult to form related conclusions because of the very multiplicity of proposals and the unresolved differences between the Department of Health, Education, and Welfare and key committees of Congress.

Again this year the Council devoted substantial amounts of time and energy to Medicare advisory and study activities. Ongoing projects were moved closer to completion and new ones were begun. The Council has had a fruitful, continuing exchange of views on these projects with staff of the Department of HEW. Future progress and direction, of course, will be guided by key decisions made by the Secretary of HEW. His view of the Council's future role and contributions will be especially decisive in light of the change in the purview of the Health Insurance Benefits Advisory Council to include the Medicaid program.[5]

[5] The revision of Section 1867 of the Social Security Act modifying the role of the Council appears as Appendix A. The earlier version of Section 1867 appears as Appendix B.

Appendix A

Section 1867 of the Social Security Act, as amended by H.R. 1 (P.L. 92–603)

Health Insurance Benefits Advisory Council

Sec. 1867.(a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or othewise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.

(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.

Appendix B

Section 1867 of the Social Security Act, prior to enactment of H.R. 1 (P.L. 92–603)

Health Insurance Benefits Advisory Council

Sec. 1867.(a) There is hereby created a Health Insurance Benefit Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospitals, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than 2 terms. The Secretary may, at the request of the Advisory Council or otherwise, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 5 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

(b) It shall be the function of the Advisory Council (1) to advise the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, and (2) to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title. The Advisory Council shall make an annual report to the Secretary on the performance of its functions, including any recommendations it may have with respect thereto,

and such report shall be transmitted promptly by the Secretary to the Congress.

(c) The Advisory Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Advisory Council such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Advisory Council may require to carry out its functions.